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## Original Communications.

### OVARITIS.

Extract from Lectures delivered in 1869 at the Hôpital de la Pitié, in Paris, by DR. T. GALLARD.  
Translated by W. L. RICHARDSON, M.D., Boston.

(Concluded from page 41.)

THE progress of ovaritis is sometimes acute, sometimes chronic, but the latter is the rule. It may even sometimes happen, especially in young women, that the inflammation does not pass beyond the congestive stage; and, in that case, especially if it is properly treated, it may disappear after manifesting symptoms which have not extended beyond two, three, or, more rarely, a single menstrual period. Usually the disease has a long duration, sometimes unusually long, assuming an almost hopeless chronic type. During its entire course we shall find that there are exacerbations, coinciding with the menstrual periods, and remissions, partially corresponding to the catamenial intervals. Sometimes it happens that, after a certain time, the remissions become of shorter and shorter duration, and that the disease assumes a persistency and activity which it did not have at first. At no period of the disease, except in cases of peritoneal complications, are there violent chills, or is the febrile reaction very severe; but, during its whole course, we frequently see slight accessions of fever, with occasional chills, usually coming on towards evening or during the night. The chills are more marked, the fever more continuous and accompanied by profuse perspiration, when, after the disease has existed for some time, suppuration begins.

The termination of ovaritis is threefold—by resolution, induration, or atrophy and suppuration. I do not know of a case, except during the course of puerperal fever, where it has ever terminated in gangrene. Of these, resolution is the most favorable, for it ends in complete recovery. This is usually the mode of termination in those cases of ovaritis which, although undoubt-

edly acute, have not lasted longer than three months, and in which the disease has not passed beyond the congestive stage. It less frequently occurs when the inflammation has passed the first stage and has entered the period of *red softening*.

Induration, which I have purposely connected with atrophy, does not insure recovery, although it often results in the cessation of the painful symptoms and the return of the general health. We should therefore regard it as a favorable termination, especially when compared with suppuration, even though we are forced to remember the physiological troubles which follow in its train. Induration may follow red softening, and the manner in which it is produced is sufficiently explained by what we know of inflammation in other tissues. Here, as elsewhere, we see the blood ceasing to flow in the inflamed organ, without, however, the size of the organ diminishing. The fluids with which it is filled gradually organize, and the final result of this organization is a copious production of connective tissue, which not only adds to the size of the organ during the period of congestion, but which also often causes it permanently to enlarge. This abnormal deposit of connective tissue does not take place without injury to the constituent elements of the tissues in which it is produced; it contracts them, crowds upon them and obliterates them. Thus in ovaries which are two or three, or even four times the normal size, but which are surrounded by a thick fibrous covering many millimetres in thickness, you do not find many ovarian vesicles. The ova have almost entirely disappeared. These alterations I have often shown you on the dissecting table; and, side by side with these enlarged ovaries, resembling in some respects a fibro-cartilaginous substance, I have shown you other smaller ones, contracted, sometimes atrophied and so shrivelled up that they are reduced some how to a mere trace. You can prove that the anatomical structure of these atrophied ovaries is precisely the same as that of those others which are thought to be hypertrophied. The ovarian vesicle and the ova have alike

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disappeared in both, and their place has been filled with connective tissue. Is there any difference between these ovaries? According to my ideas there is none, and I do not hesitate to consider the increase of connective tissue in each of these as being the only cause of the atrophy of the vesicles which should make up the proper tissue of the organs. It may be asked, may not this universal increase in size in the one case and diminution in the other depend only on the degree to which the disease has advanced. About this I cannot say, in the absence of observations extending over a period of time long enough to render them conclusive. But I consider the inflammatory nature of these lesions as undeniable, and I desire no other proof than the presence of numerous peritoneal adhesions—evident traces of a previous inflammatory state—which always surround the ovaries, both great and small, about which we are now speaking, and which, together with the changes I have just spoken of, induce me to state that induration, with or without atrophy, is one of the modes of termination of an attack of ovaritis.

These peritoneal adhesions, which fix the ovary in an abnormal position, also extend to the Fallopian tubes, which they finally enclose, rendering them immovable and imperforate. They thus become a serious obstacle to the movements which are indispensable to the completion of the act of fecundation. Moreover, the ova are destroyed, rendered few in number, or else removed from the surface of the ovary by a thick fibrous coating, rendered doubly thick by the peritoneal covering we are now speaking of, and which renders the detachment of the ova almost impossible, even if they should still exist. The result of all these conditions is that sterility is found to be an almost inevitable consequence of an attack of ovaritis which has ended in induration. Of course this sterility will not be complete unless the disease has extended to both ovaries.

Suppuration may produce the same result, but it may give rise to one still more dangerous. The pus forms sometimes in the vesicles and sometimes in the parenchyma of the ovary. In the former case it may remain encysted for a considerable length of time, unless, indeed, the little abscess thus formed should strive to gradually gain for itself a way of escape. Often the abscess, originally formed in the vesicle, will invade the parenchyma, in consequence of a communication being established between the two neighboring puru-

lent centres by the destruction of the intervening walls, and thus the ovary may be completely invaded by the disease. We sometimes see ovaries which have thus suppurred without the matter having escaped beyond the fibrinous coat which surrounded them, the natural power of resistance of the ovary having been increased by the peritoneal false membranes which formed from the effect of the inflammatory action, and which have been deposited over the entire surface of the ovary. It is impossible to calculate the time during which purulent collections following ovaritis can thus remain encysted without escaping beyond the limits of the ovary. The opening of the abscess into the peritoneum, which would at once start up a most acute form of peritonitis, rapidly proving fatal, is a very rare termination of suppurating ovaritis. The opening of the abscess through the abdominal walls is less rare. Its easiest ways of escape are by the rectum, vagina or bladder. Of these, the rectum is most directly in contact with the inflamed organ. It is on this account that ovarian abscesses usually empty their contents into the rectum. Suppuration may also proceed towards the vagina, and it happens quite often that it adopts this course, although the way is somewhat longer and the obstacles more numerous than by the rectum. As for the bladder, it is only in very rare cases that it is perforated by an abscess developed in the ovary. This occurred in two cases reported—the one by Murat, the other by Andral. In the former case the autopsy was made with unusual care, since during life pyelitis had been diagnosed without the slightest suspicion of an ovarian abscess. I have in my own practice observed a similar case, which, although it lacked the confirmation of an autopsy, was beyond the possibility of doubt a case of an ovarian abscess, following an attack of ovaritis and discharging through the bladder.

As soon as the pus formed in an ovarian abscess finds an exit, recovery may take place in this sense of the word, that the abscess dries up, and the general health of the patient is re-established, although the generative functions, at least so far as the ovary is concerned in which the abscess formed, are more fatally destroyed, even, than is the case when the disease ends in induration.

I wish now to speak of two diseases which might be taken for ovaritis. The first is renal colic; but here the sudden accession, the extreme severity of the pain,

its location in the renal region, its extension into the labia majora, as well as the thighs, will serve as a hint to the true diagnosis, which an examination will at once confirm, if there should be need of any confirmation, by an inability to find the painful tumor which is formed by an inflamed ovary.

As to the other disease, which I would have you learn to distinguish from ovaritis, it certainly would not have occurred to me to speak of it had I not myself nearly committed the error against which I would now warn you.

A woman, aged 25, who is employed in a type foundry, and has already had three or four attacks of lead colic, the last of which was about five months since, applied to the hospital, saying she was suffering from a fresh attack of the same disease. On examining and carefully questioning her, I could not discover the characteristic blue line described by Dr. Burton; the abdomen, instead of being flaccid, was slightly tense and painful, especially in the hypogastric region; pressure, instead of mitigating the pain, caused it, on the contrary, to increase, especially when exerted on a line with the left iliac fossa, about the region of the ovary. She had a chill at the beginning of the attack, and even at the time of her admission she had some fever. The pain came on very rapidly, without any known cause; it was lancinating, its maximum of intensity being at a point corresponding with the ovary. A physical examination allowed me to recognize at once the tumor formed by the inflamed ovary, a fact which at once dissipated all our doubts on the subject of a diagnosis. The symptoms, which exist in both diseases, and which might justify our confusion, are the acute abdominal pain and the constipation, accompanied sometimes by nausea and vomiting.

I pass now to the consideration of the question whether some of the causes of ovaritis are not capable of imprinting on the inflammation some peculiar modification, so as to form a new species or variety of the same disease. Of these modifications the more generally admitted are those which occur under the influence of rheumatism, gonorrhœa, tuberculosis or cancer.

So far as the influence of rheumatism is concerned, it is very necessary for us to be careful and not confound with it those effects which result merely from exposure to cold, nor to consider as dependent on

rheumatism all those cases in which the disease began with a chill.

I recognize the rheumatic character of ovaritis only in those cases where it develops itself in a rheumatic subject and simultaneously with other rheumatic manifestations. These cases are very rare: Kruger and Murat, who admit the existence of rheumatic ovaritis, have not cited a single example; Copland has reported only two cases. At present there is one patient in the hospital who is suffering from this form of the disease. This woman is 26 years of age. She is strong, vigorous, and well formed, but shows that peculiar color and transparency of the skin which you so constantly observe in rheumatic patients, although yet she has never had any other attack of rheumatism than the one for which we are now treating her. She has menstruated regularly since she was 16 years of age. The only pregnancy, through which she has passed, ended regularly four years ago at full term and without the least accident. She has never shown any symptoms of disease of the generative organs. Just a month ago, when the catamenia had been present for three days, she remained for a long time exposed to cold and wet. Soon after going to bed, she was seized with a violent chill, lasting over half an hour. The catamenia were at once arrested. The next day she complained of malaise, lassitude, fatigue, a feeling of great weakness, and headache. She suffered from thirst, anorexia and slight nausea, but complained of no acute pain in any part of the body. She dressed herself and remained up about the house four hours. It was the fatigue she experienced and not the pain which forced her to lie down. It was not till after eight days of this general malaise, unattended by any well-marked symptoms, that she was seized with a violent chill, which lasted two hours, followed by a high fever, giving way to a profuse perspiration. The morning after this chill, and the ninth day after the exposure to damp and cold, the woman found herself literally fastened to the bed, all the joints of her body being red, swollen, and extremely painful. She complained almost simultaneously of an equally severe pain in the abdomen, in the region of the left ovary, and in the chest at the base of the thorax on both sides, but especially the left. From the time when this new attack began, the fever and chill persisted, returning daily, although with less severity than at first, but always accompanied by a profuse diaphoresis. It

was not till the end of these six days, or in other words till the beginning of the sixteenth day of the illness—if we begin to reckon from the first exposure to cold and wet—that the woman came under our charge. The joints were then nearly free from pain. There was a dry cough, and although the tenderness of the left side had almost completely disappeared, there still existed at the left posterior base of the thorax a slight dulness, with feebleness of the respiratory murmur, showing the presence of a slight pleuritic effusion. The skin was hot, the pulse feeble, 104. The abdomen somewhat more tense than usual, painful on pressure all over the sub-umbilical region, and especially in the left iliac fossa. Palpation could discover no tumor, but a vaginal examination showed nearly the same physical signs which we found in the patient of whom I spoke at the beginning of these lectures. The body of the uterus was inclined backwards, and along the left side, on examining very high, a slight tumor was perceived, a little larger than the thumb, movable and escaping from under the finger and excessively painful to pressure. A lateral movement given to the uterus at once produced a most acute pain.

From these symptoms you recognize, beyond all question, an inflammation of the left ovary. It was subsequent to the invasion of rheumatic arthritis that the ovaritis made its appearance, revealing its presence by those morbid symptoms which are so peculiar to it. The ovaritis was here evidently of the same nature as the general arthritis which preceded it, as was also the pleuritic affection. The subsequent history of the case also pointed to the same origin. After remaining ten days under treatment she desired to be discharged. The left ovarian region was still a little painful. On returning to her work, which constantly exposes her to drafts of air, she had a slight relapse of the rheumatic symptoms, but no further ovarian inflammation. The catamenia returned at the next regular period, the ovaritis ending in resolution.

Ricord and later Boureau, Bernutz, and a number of other writers, have considered disease of the ovary as a frequent complication of gonorrhœa. It is to be remembered that it was in their particular department of the Lourcine Hospital, where gonorrhœa complicated the larger part of the diseases they were called upon to treat, that their statistics were collected. This fact alone explains why the proportion of cases of ovaritis attributed to gonorrhœa

is so great, a proportion which is not borne out by the observations made elsewhere.

Without wishing to deny the existence of this form of the disease, of which I treated a case in this hospital some three years since, I agree entirely with the opinion of Guérin, who considers ovaritis as one of the rarest complications of gonorrhœa. I have not included syphilitic ovaritis among the varieties of this disease, although I cannot doubt of its existence. I believe that I have myself seen one case, at least, perhaps two, in which a considerable swelling of the ovary could, according to my own ideas, have been explained in no other way.

In cases of uterine cancer the ovaries are not unfrequently inflamed, and yet there is no extension of the original cancerous disease to the proper tissue of the ovary. This form of ovaritis, essentially secondary, may be considered merely as an incidental phenomenon dependent on a grave disease. For this reason it is therefore of but slight importance. Ovaritis, however, may become the source of real danger to a patient affected with cancer, for the reason that, under the influence of any irritation, however slight, the inflammation may assume a grave character and rapidly extend to the peritoneum. This fact explains, in some cases, the accidents which so frequently and surely follow attempts at cauterization or excision, when used in the treatment of uterine cancer.

I have shown you how phthisis may act as a predisposing cause of the ovarian inflammation. I may add that ovaritis, developed under these conditions, assumes more readily than in other cases a chronic form, and is especially characterized by its persistency as well as its slight tendency to resolution. While you need never fear when you have to deal with a patient whose previous health you know about, and whose family history shows that she has no hereditary tubercular tendency; you must, on the other hand, be on your guard lest, in phthisical patients, the ovaritis cause the phthisis to proceed with greater rapidity than usual, and the phthisis cause the ovaritis to assume a chronic persistency and an unusual tendency to suppuration.

I pass now to the prognosis in a case of ovaritis. It rarely places life in jeopardy, when it occurs as the primary disease, unless, indeed, it goes on to suppuration, in which case it may have a rapidly fatal termination. Except in the rheumatic form, and when it does not pass beyond the con-



gestive period, ovaritis rarely terminates in prompt and complete recovery. In the great majority of cases it lasts many months and then ends, after all, in incurable sterility. When it occurs secondarily, as in cancer or phthisis, it becomes a dangerous complication, which may give rise to serious accident, and be of itself sufficient to hasten death.

The treatment of ovaritis differs materially from that of the other uterine or peritoneal diseases. Like the latter diseases, ovaritis demands antiphlogistic measures; but, in simple ovaritis, they should be employed with much more care and restriction than in metritis or peri-uterine diseases. At the beginning, especially in cases clearly inflammatory in their nature, some bloodletting is useful, especially in strong, robust women. From four to twelve leeches may be applied, either on the loins or the hypogastric region; but usually I prefer to use scarifying glasses, to the number of four or six, applied to the latter region. These have the power of allaying the pain more directly than leeches. This first operation of bloodletting may be repeated in about five or six days, if the persistency of the inflammatory symptoms requires it. In the first stage of ovaritis, I never make use of leeches applied to the cervix uteri. These I reserve till a later period, especially in case the disease seems to show a tendency to become chronic and the congestion of the ovaries at the monthly periods produces no aggravation of the inflammatory symptoms. Then it is that I apply from two to four leeches to the os tincæ a few days before the expected appearance of the catamenia, and I repeat this operation some days after their disappearance. This method of procedure has the advantage of counteracting the dangerous effect produced by the menstrual congestion, and also favors resolution; and I often resort to it for many consecutive months, but without using any other method of bloodletting in the intervals. The loss of blood which follows this method is so small that it can be borne even by the weakest women, for it becomes a part, as it were, of their regular monthly hæmorrhage.

As an adjunct to this, although often as the principal treatment when the withdrawal of blood is contraindicated, it is necessary to have resort to local emollients of all sorts, and to narcotics which we can combine with the emollients; for example, the prolonged warm bath, the sitz bath morning and evening, with decoctions of mucilaginous and narcotic plants, poultices

sprinkled with laudanum, injections of simple water or water and laudanum. These are the methods which avail most during the first period. The food should be light, somewhat plentiful; and it is often advantageous to purge the patient occasionally with castor oil or calomel. Later, when the congestion has been succeeded by induration, there are two objects which we must attend to—first to relieve the pain, and second to procure reabsorption of the plastic material which has been deposited, not only in the parenchyma of the ovary, but also on the external surface of the peritoneum. Without, therefore, giving up the use of the narcotic emollients of the first stage, the baths, poultices and injections, it will be necessary to add to them some which are more efficacious in their soothing effect. An injection of about a quart of water, rendered mucilaginous in its nature by the addition of starch, and containing from ten to fifteen drops of laudanum, will produce a most quieting effect when it is administered in the evening, and it may be retained all night. Aran used to pour a certain amount of laudanum into the vagina, having previously introduced a speculum, and then added starch, forming, as it were, a sort of paste, which remained in its place twenty-four hours. I have often employed this method, the efficacy of which, although very useful, is much less marked than would be supposed from the amount of laudanum used. It is at this stage of the disease especially that blisters should be used. Their action in promoting resolution is not as great as we could wish, and I often prefer the actual cautery, applied over the hypogastric region for a space of one or two inches beyond the median line. But the application of blisters has, however, the advantage of opening the way for the administration of morphia by the endermic method, and thus they render good service in a disease in which the element of pain plays so important a part. We should not rely exclusively on local applications for the relief of this pain, but should administer narcotics, and especially opium, by the mouth. Many patients pass a comfortable night after taking a grain or a grain and a half of the extract of opium, and I do not believe it is often necessary to exceed that dose, although it might be doubled without inconvenience; it is better, however, not to give it all at once, but in divided doses—perhaps a fifth of a grain every two hours till it produces sleep, or at least drowsiness. You will often find it of great service to

unite opium with calomel, from which combination you will obtain a purgative action as well as a promotion of resolution. As to the latter effect, it is on blisters, to which I have alluded, and especially on the actual cantery, that I chiefly rely. It is perhaps advisable to begin with a series of scattered blisters, which you can dress with mercurial ointment, or paint over the abdomen, every two or three days, with tincture of iodine. As for other absorbents, such as iodine ointment or the internal administration of iodine, do not expect much from them.

Baths and douches are of great value. Tepid alkaline baths may be employed at the outset. As for douches, especially the cold douche, it is necessary to use them only after the complete disappearance of the congestion. I have often seen a dangerous relapse follow the premature employment of this mode of treatment—a mode which is very valuable, but which must be used with great caution. In the treatment of a disease of so lasting and obstinate a nature, mineral waters are very useful. Some waters may have a direct influence in promoting resolution; such is the case with the alkaline waters and those containing bromine or iodine. You may use with advantage, especially if the disease is of long standing, those waters whose tonic and stimulating action will effect the general health of your patient. It is only with this end in view that you should resort to sulphur springs or sea-bathing; or, what is more simple still, to a residence in the country.

When ovaritis ends in suppuration shall we open the abscess or leave it to nature? If it is encysted we must leave it alone rather than to run the risk of injuring some important organ in our attempts to reach it. It is therefore only in those cases where it begins to make an external opening, perhaps into the vagina, or the rectum, or through the abdominal walls, that there is some advantage in an operation. In all these cases it is sufficient to make a simple incision with a bistoury, and this puncture should be made at the most prominent point. When the opening can be made in the vagina it is especially advantageous to make it. Apart from these cases, and those where the abscess attempts to make its exit through the abdominal walls, it is better to await its spontaneous opening, which usually takes place into the rectum.

The hygienic condition of a patient cannot be too carefully attended to. It is not well to maintain for too long a period the

strict rules which we recommended for the first few days of the disease. The food should be substantial, and as strongly concentrated into a small body as possible. Marked changes of temperature should be avoided, and especially exposure to cold. For this purpose it may be necessary to wear a flannel garment next to the skin, and especially over the abdomen. Moderate exercise, on foot rather than in a carriage, the jolting of which may produce a painful effect on the diseased organ, should be recommended. All fatigue, mental or physical, should be avoided. You have not of course forgotten that every act, even although a physiological one, of the generative organs is brought about by an increase in the activity of the circulation. Theoretically, then, we are induced to warn patients, attacked with ovaritis, to avoid whatever will produce congestion of the generative organs, no matter how transient its effect may be, and consequently to abstain from all sexual intercourse during the course of the disease. But here, as is often the case, the theory is far from being in such complete harmony with the practice as we might desire, and we have the right, nay, more, it is our duty to question whether so absolute a prohibition may not, in cases where it is rigidly observed, do more harm than good. I am myself perfectly persuaded of the harm thus done; so that while recommending some restrictions as regards the conjugal relation, I am careful not to make my directions too absolute, and my patients rarely suffer in consequence.

I go even further, and I ask if, in certain cases, the sexual act may not exert a favorable influence on the progress of ovaritis, and even constitute our best mode of treatment. I refer to cases where the act may be followed by conception. Bischoff has shown that, in pregnant women, about the fourth or fifth month, the ovary is small, dry, pale, shrivelled up, and contains but little blood, or in other words, is in a condition precisely opposite to that which marks the first stage of inflammation. If, now, it were possible to place an inflamed ovary in this condition, we should do more than could possibly be done by the aid of the most direct treatment, inasmuch as this state of repose would last some months, during which the ovary would be free from those periods of congestion which are, as you know, the stumbling-blocks in the way of treatment. Examples are not wanting of old peri-uterine inflammations being cured by a supervening pregnancy.

These considerations have great practical interest for you. You will often be consulted by families to know whether it is necessary to hasten or delay the marriage of a young daughter who is under your care; and you will find the mother less inclined to expose her child to the consequences of marriage, since she has observed that the catamenia are irregular, painful and accompanied by symptoms which may cause you to suspect inflammation of the ovary. If it is so, if you recognize this state of unnaturally increased periodic congestion, which causes you to suspect that an attack of ovaritis is threatening, or which even is actually just beginning, advise the marriage. You should recommend this for two reasons: 1st, because the young girl is still capable of becoming pregnant, although she may become sterile, if you allow the disease to grow; and, 2d, because, if fecundation does take place, she will probably have a sure recovery from a condition that is not without its inconveniences and its dangers.

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#### BLUE PUS.

By A. H. NICHOLS, M.D., Boston.

In the *Wiener Med. Zeitung* of April 3, 1870, is reported the result of a series of elaborate experiments undertaken by Dr. Edward Schwarz, at the request of Prof. Zeissl, throwing considerable light upon the nature of the parasite which imparts this peculiar tinge to pus.

This rare phenomenon has been noticed several times during the past year in the Vienna Hospital, and of late has made its appearance in the wards of Prof. Zeissl, in the case of a patient suffering from a suppurating inguinal gland.

The blue tinge was found to be imparted to the charpie and compresses which were used to dress the wound, and it was invariably noticed that this color was much less decided in the charpie which lay in immediate contact with the suppurating surface, than in the moistened compresses more exposed to the air.

The reaction of this colored liquid was neutral.

Upon examining the colored charpie under the microscope (magnifying first 400, then 1000 diameters), the separate fibres appeared quite colorless, and nothing could be detected but pus corpuscles, and numerous minute objects in motion, having a variable form, not unlike vibriones.

As repeated examinations with the microscope gave the same negative results, a different method was next chosen to ascertain, if possible, the cause of the change of color. Linen threads were carefully cleansed and placed for fifteen minutes in immediate contact with the wound. These were next removed and laid upon watch crystals containing a solution either of sugar, albumen, glycerine or serum, where they were allowed to remain under a bell-glass in a moist temperature of 32°-36° C.; the air within being renewed twice each day, and purified by being passed each time through sulphuric acid.

A second series of experiments consisted in suspending linen threads which had been previously immersed in a solution of albumen or sugar, in a moist temperature of 35° C.

Finally, similar fibres were exposed upon boiled potatoes, bread, and paper, in the same temperature.

In each case the results were alike positive and satisfactory, and tend to prove: First, that, in certain conditions of the atmosphere, germs or spores in the air are deposited upon moist surfaces. Secondly, that these germs, when placed in a liquid suitable for their nourishment, undergo uniform changes in form and color. Thirdly, that under other circumstances, the development of these germs is at once arrested.

The linen threads treated in the manner above described, were carefully watched from day to day, and the following changes observed. Upon examining the fibres soon after their removal from the wound, numerous round cells were detected, each containing an albuminous-like fluid (protoplasma) in which were several small nuclei (plasmakörmchen). It was next found that the membranous walls of these cells broke up and disappeared, but that the nuclei, contained in the plasma, and nourished by the same, continued to live in a changed condition.

It was noticed soon after the death of the cell membrane that these nuclei began to move and increase in number, by means of cell proliferation, arranging themselves in a row, of which the end cell was generally the largest. It is in this form that they have been known and described as "Bakteridie."

The cells are finally seen to lengthen, and form a long delicate body, called, when single, Leptothrix, or if it ramifies, Leptomitrus, and classified in the latter form by Kützing among the Algæ.

Sometimes the cells were seen to separate

from one another, so as to form, not a long line or chain, but a circular body, sometimes in motion, at others still. In the latter form they have been called by Hallier "Micrococcus"; by Karsten, "Microgorgidien." The farther history of these parasites was found to depend upon whether they were nourished or left to perish slowly.

When placed in some liquid suitable for their nourishment, it was ascertained that they underwent a further transformation, increasing in size, and assuming various forms and even colors, according as the liquid in which they were immersed contained albumen, oxalic acid, sugar or serum. In the serum of the blood, their growth was found to be particularly rapid.

The changes in color are described as follows:—Upon the second day, the parasites began to impart a light yellow color to the albumen or serum in which they were contained. This color became darker on the third day; upon the fourth day it was green, and so on through the darker shades.

In albumen, however, no change in color was noticed after the fourth day, while in glycerine the result was negative from the very first.

Experiments with bread, litmus paper and various vegetables gave equally decisive results.

In conclusion, experiments are given showing how the growth of the parasite and the change of color may be arrested. This may be done by heating the liquid to a temperature of 40°–60° C., or by subjecting it to a stream of ordinary coal gas, or ammonia, or carbonic acid gas.

This discovery will explain the phenomenon which caused no little local excitement in the village of Langenlois, Austria, in the summer of 1868, where it was noticed that bread and pastry, when allowed to stand beyond a certain length of time, suddenly assumed a red color.

It is interesting, moreover, in connection with the phenomenon of red snow, recorded as having fallen in Salzburg in the year 1855, and noticed more frequently in the Arctic regions.

DR. TOWNSEND, in a report of the cholera epidemic of 1868, shows that the epidemic ravages frequently visit villages built on rock, where no subsoil infiltration can take place. He is rather in favor of the theory which attributes cholera to polluted water.

—*Dublin Medical Press and Circular.*

## Selected Papers.

We extract the following from the *Edinburgh Medical Journal* for July:—

### CASE OF PUERPERAL TETANUS COMING ON NINE DAYS AFTER PARTURITION, AND TERMINATING FATALLY IN FORTY HOURS.

By WILLIAM CRAIG, M.B., C.M., L.R.C.S.E.

Mrs. S., aged 37 years, native of Ireland. Had previously seven children, all of whom were born in South Australia. Her "labors" were always speedy and her recoveries good. She mentioned to me that on her seventh confinement she had retention of the placenta, but notwithstanding she made a good and speedy recovery.

The veins of her right leg were varicose, and on several occasions before her confinements one of these veins (a little above the internal malleolus) burst and caused considerable hæmorrhage. This had occurred before several of her confinements in Australia.

On the 4th of September last, I was called in to arrest the hæmorrhage which had occurred from this old wound. This I accomplished easily by means of a pad and bandage. On the 30th of September I was again sent for, to arrest the hæmorrhage from this same wound.

The next time I saw the patient was on the evening of her confinement.

On the evening of Wednesday, October 27, shortly before midnight, I was requested to come immediately to see her, and in five minutes afterwards I was at her bedside.

On entering her bedroom, I learned that several hours previously she had been delivered of a strong, healthy boy, a woman having acted as accoucheur. The placenta was still retained, although the nurse had made several unsuccessful attempts to remove it. This midwife was very averse to a medical man being called in, and only consented after repeated attempts to remove the placenta had failed.

I found the patient very weak, chiefly from hæmorrhage. The uterus was flabby and uncontracted. Having caused the uterus to contract by external manipulation over the abdomen, I was very soon enabled to remove the placenta, being careful at the same time to remove all clots from the vagina. I found, however, a large

amount of coagulated blood in the bed beside the patient.

By the time the placenta was removed the patient was very faint, and I accordingly administered a little stimulant, and she soon revived. The patient passed a good night, and told me next day that she had slept well, and never was better after any previous confinement. For more than a week she appeared to be making a fair recovery. The secretion of milk was very copious; and on Thursday, November 4, eight days after her confinement, the patient was so well that she insisted on getting up out of bed, but as her pulse was fully 80 per minute I refused to allow her. Her pulse since her confinement had generally kept above 80, and sometimes was as high as 100 per minute.

The high pulse was suggestive of mischief, but as her appetite was good, and the secretion of milk abundant, I hoped that no bad results would follow.

On the morning of Friday, November 5, whilst she was at breakfast, she suddenly felt something wrong with her throat when swallowing some tea. She told me of this when I saw her in the course of the forenoon, but I thought she had caught cold, and told her to wrap her neck in flannel, and at the same time gave her ten grains of the compound powder of ipecacuanha.

On the afternoon of the same day, I was sent for, as she was worse; but being professionally engaged elsewhere at the time, it was several hours before I could see the patient. Meanwhile, another medical man was called in to see her, who ordered a mustard poultice to be applied to the throat. I saw her in the course of the evening, and found that the mustard ordered by my brother practitioner had produced no benefit. I found, moreover, that now she had great pain and difficulty both in opening her mouth and in swallowing. Her own idea was that the "pap of her throat" (uvula) had fallen down, and that if I could only lift it up she would be all right. Of course I knew she was mistaken, but I mention the fact to describe the patient's own feelings at the time. She could not open her mouth sufficiently to allow me to see as far back as the uvula, and she had very great difficulty in swallowing. On external manipulation, however, no pain was elicited, showing the absence of inflammatory action; in fact, she experienced pain only when trying to open her mouth or when swallowing.

Although at this time there was a certain

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amount of trismus, I could not bring my mind to the conclusion that it was a case of tetanus. Her bowels being somewhat constipated, I ordered her some opening medicine. Hoping it was only a spasm of the muscles produced by cold, I ordered hot poultices of bran and chamomile flowers, along with hot fomentations of the same. All these were applied most faithfully and effectually during the whole night.

Next morning (Saturday, 6th), between 6 and 7 o'clock A.M., I was sent for, as she was no better but worse, the poultices and hot fomentations, although constantly applied all night, having produced no change for the better.

I may here mention, that the patient was fully convinced that something was sticking in her throat, and she wished me to cut in and see what was wrong and rectify matters. Such was her feeling.

It was agreed by the husband and myself to call in another doctor in consultation. I accordingly went direct to Dr. Patrick Heron Watson, who kindly came and saw the patient with me. She could still swallow, but with great difficulty, and Dr. Watson was unable to see the back part of her mouth, owing to the rigidity of the masseter and temporal muscles. The pulse was about 130 or 140 per minute.

After a careful examination of the patient, Dr. Watson gave it as his opinion that it was a true case of tetanus. At his suggestion I ordered Indian hemp, 25 minims to begin with, and 10 minims every hour afterwards; also to continue the poultices and hot fomentations. The medicine I gave the previous evening not having acted sufficiently, I ordered a turpentine enema to be given. This had the desired effect of thoroughly clearing out the bowels. The fæces had a most offensive smell.

Notwithstanding all our treatment, the patient got rapidly worse; and after she was unable to swallow, I ordered nutrient injections per rectum, and even gave the tincture of Indian hemp in the same way.

About mid-day on Saturday, in addition to well-marked trismus, there was added opisthotonos, the longitudinal muscles at the back of the neck being the muscles chiefly affected. They were in a state of tonic spasm. I ordered the hot fomentations and poultices to be applied to the back of the neck also. All our treatment, however, proved unavailing, for the disease, which was now well marked, made rapid progress. The patient was perfectly conscious, and described her feeling as if a "ton weight was dragging her head back."



wards." What added greatly to the patient's sufferings was an accumulation of mucus in the throat which could not be got rid of, and which produced a sensation of constant suffocation and impending death.

At this stage of the disease I witnessed an interesting but painful phenomenon. Every five or ten minutes her head was observed to jerk a little backwards, then remain stationary for other five or ten minutes, and then suddenly to jerk again backwards. This interesting phenomenon was well marked, and continued as long as I saw the patient. It had all the appearance of a screw gradually but surely drawing the occiput back towards the shoulders. Jerk after jerk reminded one of another turn of the screw. In short, opisthotonos was now well marked. The expression of the countenance was characteristic of the disease. The teeth were quite exposed, the angles of the mouth drawn much backwards, giving a very ghastly appearance to the patient. The "risus sardonius," so characteristic of this disease, was in this case very distinct.

I saw her for the last time about 1, A.M., on Sabbath morning, and in two hours afterwards death terminated her sufferings, the disease having lasted forty hours. From the symptoms described to me I believe the immediate cause of death was asphyxia.

There can be no doubt but this was a case of tetanus. In this opinion I am fully confirmed by Dr. Patrick Heron Watson. The trismus, opisthotonos, exposure of teeth, and ghastly grin (risus sardonius), were all well marked. It was, moreover, a case of tetanus coming nine days after parturition at the full time. Of this latter fact there can be no doubt. The deceased expected her confinement in the beginning of September, at least six weeks before it took place; and the child was much above the average in size—in fact, it was the largest new-born child I have ever seen.

There was no appearance of either peritonitis or metritis. The lochial discharge still continued to flow. It threatened to stop, but I ordered hot fomentations, and by this means it readily continued discharging. The secretion of milk continued till the day of her death. Let it also be borne in mind that it happened in Edinburgh during the cold weather of November. The patient, however, was only a few months returned from Geelong, South Australia, where the greater part of her married life had been spent, and where her other seven children were all born. It is

necessary to bear these things in mind, since tetanus is a disease much more frequent in warm countries than in cold ones; but I am far from asserting that the fact of her having spent many years in the warm climate of Geelong had anything to do with bringing on tetanus in this case.

#### A MODIFICATION OF THE ADVANCEMENT OF THE MUSCLE.

By Dr. R. LIEBRICH, of Paris.

ANATOMICAL researches with regard to the capsule of Tennon, and its connection with the muscles of the eye, the conjunctiva and the caruncle, have induced me for the last four years to modify the operation for strabismus. The following are the results of these investigations:—

1. The union of the muscles with Tennon's capsule is a double one. On one side, an annular union of the posterior part of the capsule and its sheath-like processes directed toward the orbit with the belly of the muscles; on the other, a firm adhesion of the anterior half of the capsule with the surfaces of the muscles which project into the hollow of the capsule.

2. The conjunctiva is firmly united with the outer surface of Tennon's capsule from the edge of the cornea as far as to an irregular, annular, well-defined boundary line, and in this way it is indirectly in very important relation to the muscles of the eye.

3. The caruncle, together with the plica semilunaris, rests on a ligament which passes from Tennon's capsule to the edge of the orbit. The contraction of the rectus internus necessitates that by the turning in of the eye this ligament is stretched, and thereby the caruncle which is placed upon it will be drawn toward the inner margin of the orbit. But at the same time also the outer edge of the caruncle, together with the plica semilunaris and a portion of the cornea lying next to and behind it, will be drawn backward and form a fold. This occurs partly because the conjunctiva, in the movements of the eye, lies to a certain extent close to the globe as far as a certain line, but partly also because the muscle, on account of its union with the anterior half of the capsule, draws the latter backward in its contractions, where the conjunctiva, plica semilunaris and caruncle, which are united to it, are obliged to follow.

The procedure to which these anatomical investigations have led me is the following:—In the tenotomy of the rectus internus, I raise up with the forceps a fold

of the conjunctiva at the lower end of the insertion of the muscle, cut it through with the scissors, pass through the opening between the conjunctiva and the capsule, separate these two membranes carefully as far as the plica semilunaris, and divide the latter likewise, as well as the caruncle, from the subjacent parts. After having completely freed from the conjunctiva all that part of the capsule which is important for the retraction of the muscle, I separate the insertion of the muscle from the sclerotic in the usual manner, and prolong at the same time the vertical section of the capsule above and below, the greater the retrocession is to be; and then I always close the conjunctival wound with a suture.

As the advantages of my proceeding, I have already given notice two years since, first in the *Archiv für Ophthalmologie*, of the following:—

1. A greater freedom, and a much greater interval for the graduation and the distribution of the operation for strabismus.

2. The avoiding of the sinking in of the caruncle, and every trace of a scar, which are sometimes left behind in the ordinary tenotomy.

3. The avoidance of more than two operations in the same individual, and also of more than one on the same eye.

It has never entered my mind, as has been erroneously affirmed, to recommend the correction of a high degree of strabismus by a single operation.

After having described this modification of causing retrocession of the muscle more than two years since, I now first communicate an analogous modification of its advancement, for the simple reason that, though I had very soon numerous opportunities to try the proceeding for common tenotomy, the indication for advancement occurs much more seldom. But now I have further been able sufficiently to observe the results of the latter, to feel justified in recommending the following proceeding.

After a broad vertical incision of the conjunctiva in the neighborhood of the insertion of the muscles, or better somewhat behind it, I burrow beneath the conjunctiva with the scissors, both toward the cornea and the opposite directions so as to separate it completely from the subjacent Tenon's capsule. Afterwards I make the tenotomy and cut the capsule above and below, in the direction of the insertion of the muscle, so far that the muscle and the part of the capsule that lies upon it are completely movable, and may easily be brought forward to the border of the

cornea. Here I fasten them in the following manner. I pass two fine needles, attached to the two ends of the same thread, above and below, at a distance of about one line from each other; first through the capsule and the end of the muscle, and then from behind forward through the conjunctiva, and tie the loop over the conjunctiva. Of such sutures, or rather loops, I apply at least two, one in the neighborhood of the upper, and the second in the neighborhood of the lower border of the muscle. After the muscle and the capsule are in this manner fixed beneath the conjunctiva close to the edge of the cornea, I carefully unite the conjunctival wound with several sutures. If the attainment of the mechanical design demands the shortening of the muscle, this presents no difficulties; on the contrary, this proceeding favors, when necessary, the removal of a portion of the anterior extremity of the muscle and also of Tenon's capsule.

By the latter procedure, we are able to produce a considerable effect on the prominence and apparent size of the eyeball.

But the advantage of this proceeding lies in this, that we avoid thereby the cutting out of the conjunctiva, which very often leads to essential inconveniences, in particular long remaining irritation, tight folds impeding the movements of the eye, &c. In every case it is more rational to spare the conjunctiva, if its excision is not requisite to attain the mechanical effect.—*Archives of Ophthalmology and Otology.*

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## Medical and Surgical Journal.

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BOSTON: THURSDAY, JULY 28, 1870.

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### A RESOLUTION WITHOUT LEGAL FORCE.

In presenting, with some diffidence, our views on the following resolution, passed at the recent annual meeting of the Massachusetts Medical Society, we offer them for the consideration of our readers, fully aware that those who voted in accordance with the spirit of the resolution did so with the conviction that the interests of the medical profession and the public generally would be subserved by such action on their part. The resolution is as follows:—

"Resolved, That the Massachusetts Medical Society hereby expels from fellowship all those who publicly profess to practise

in accordance with any exclusive dogma, whether calling themselves homœopaths, hydropaths, eclectics, or what not, in violation of the Code of Ethics of the American Medical Association."

It should be remembered that expulsion can only be effected in accordance with the By-laws of the Society, as follows:—

"TRIALS FOR OFFENCES.

"XXXI. 1. When charges of infractions of the By-laws shall be duly made against any Fellow of the Society (VII., VIII., IX.), the President shall thereupon select five of the Commissioners on Trials (XIII.), who shall constitute a Board of Trial for the pending case. He shall appoint a time and place for the meeting of said Board, and shall notify the Commissioners appointed, also the complainants and the accused party, of said time and place.

"2. The said Board of Trial shall be empowered and required to meet as above provided, and three members shall constitute a quorum. They shall proceed to organize themselves, and to hear and try the charges aforesaid; and, if convinced that the charges have been substantiated by the complainants, they shall convict the accused, or, if otherwise, they shall acquit him; and, in case of conviction, shall pass sentence, such as the laws of the Society authorize, which sentence shall take effect from the date of its passage.

"3. If, after due notification, the accused party shall fail to appear at the time and place of trial, without satisfactory excuse rendered at the time, he shall be considered as admitting the truth of the charges against him, and shall be liable to sentence accordingly.

"4. Upon showing to the Councillors such cause as shall by them be deemed reasonable therefor, the accused shall be entitled to a revision of his trial by the Councillors, who may, according to their judgment, confirm or reverse the previous decision; and this shall be final.

"5. Legal counsel shall be inadmissible; but members of the Society may be heard as advocates on either side during the trial.

"6. The Recording Secretary of the Society shall be Secretary of the Boards of Trial, and shall attend all trials, and keep a record of the doings of the Commissioners at said trials. He shall enter the several charges preferred, and the result of trial in each case, on the Records of the Society, and shall communicate the same to the President of the Society, and to the Presi-

dent of each of the District Societies, at the close of the trial.

"7. Each Commissioner, and also the Secretary, shall be entitled to receive from the Treasury three dollars per diem for the time necessarily spent in trial and in attendance on trials, with the necessary expenses of travel, as may be decided by the Board; and each Commissioner who shall neglect or refuse to attend the trial for which he has been designated, without offering an excuse which shall be satisfactory to those who do attend the same, shall pay a fine of ten dollars to the Treasurer of the Society.

"8. The President of the Society shall fill all vacancies by death or resignation, or by other causes, whether of the Commissioners of the District Societies or in the Boards of Trial."

This is the only machinery now existing for expulsion, and its form must of course be strictly complied with. It will be observed first, that it applies only to individuals, and cannot be brought to bear upon bodies or classes of members. It is John Doe, the individual, and the practitioner of an exclusive dogma, who is to be thus indicted, and not a class, whether homœopaths or other practitioners; and, secondly, John Doe is to be subjected to a prescribed form of trial. Of course, the resolution before quoted is wholly nugatory and falls to the ground. It may be unnecessary to explain, at least to those who were present, that this action was taken at the last moment before the annual oration; the hour for which having arrived, anything like deliberate discussion was out of the question.

Nobody doubts that it expresses the sentiments and wish of a large majority of the Society. It was the expression of a feeling which has been uniformly, justly and strongly held by the Society for the last thirty years in respect to homœopathy, and, ever since its foundation, in regard to contemporaneous quackery. But grave doubts have always been entertained as to the expediency or possibility of accomplishing the desired end. It was remarked at the meeting in question by Dr. Corlies, a delegate from the New York State Medical Society, that that body had abandoned any attempt to get rid of homœopathic practi-

tioners, and contented itself with overlooking their existence. This has hitherto been the policy of the Massachusetts Medical Society. Unable to get rid of them, it has avoided giving to them the benefit of opposition or of martyrdom; and this, we think, will be still found, on the whole, the best policy under the circumstances.

Upon reference to the charter of the Society, we find little to aid members in this emergency. The Preamble recites that "the benefit of medical institutions, formed on liberal principles and encouraged by the patronage of the law is universally acknowledged," and the charter provides, among other things, that "any person of good moral character, found to possess the qualifications prescribed by the rules and regulations of the Society, shall, upon examination by the Censors, and not otherwise, be admitted a Fellow; and the Fellows shall have power to suspend, expel, or disfranchise a Fellow of the Society." The fair construction of this provision seems to be, that any person, qualifying himself by proof of a good moral character, and by passing the examination prescribed by the Censors, which examination must be conducted reasonably, with the fair purpose of ascertaining the scientific qualifications of the candidates, is entitled to membership. As he is not entitled to become a member by reason of his holding any special opinion, or theory in medicine, so, it would seem, he cannot be excluded from membership if he possesses every qualification of morals, and of scientific education and knowledge, by reason of his holding any such theory or opinion. If this were otherwise a majority of the Fellows might exclude every candidate, however virtuous and eminent, who failed to agree with them upon any point of theory or practice. If, then, the holding of certain opinions cannot be good ground for excluding a candidate otherwise qualified, does it not follow that it is no ground for expelling a Fellow who has been found qualified or admitted?

It is to be noted that the words of the resolution touch only those who "publicly profess to practise" such a theory or dogma; but there seems to be no just distinction between holding and acting upon the

theory or opinion. The force and purpose of the resolution is to expel those who embrace the doctrine; and, if to put the theory in practice is an offence deserving expulsion, the offence must consist in the enormity of the theory itself. We are not aware that this point has been brought before our Courts; but it may be remarked that in the case of *Barrows vs. The Massachusetts Medical Society*, 12 Cushing's Reports, p. 402, the member was expelled for a breach of morals and his disqualification as a homœopathist, though one of the grounds taken was not passed upon by the Court. The Society of course has the right to make by-laws, and to prescribe regulations for admission and membership; but these regulations must be reasonable. The doubt which we express (and in treating a legal subject, we speak with diffidence, and express ourselves only in the form of doubt) is whether the exclusion or expulsion of a person, otherwise qualified, for holding or acting upon, a theory, or opinion in medicine, not in itself immoral, is a reasonable regulation. If the homœopathists should at any time obtain a majority of the Society, would it be thought reasonable, and within their legal powers, to exclude or expel all other practitioners?

The Society may properly exact from the candidate a certain amount of knowledge in a certain direction, but it cannot arrest the knowledge at that point. It is not responsible for what the admitted candidate may add to his knowledge, nor for what he may choose to do with it afterward. He may practise veterinary surgery, housepainting or homœopathy, and, if we are right, the Society cannot control his course in this respect. If he practises homœopathy dishonestly, the matter of dishonesty and not of homœopathy is then in question. Let any member of this Society imagine himself to be prosecuted for damages claimed by another member of the Society who had been expelled for his homœopathic practice. Let the supposed defendant peruse the first paragraph of our charter, which alone indicates the motive and purpose of the legislature who granted it, and maturely consider upon what ground he would defend himself. Or, let him actually

go to the present Massachusetts Legislature and ask them what peculiar views of medical practice they originally intended or profess now especially to endorse. Really, we are led to the conviction that the less we meddle with this whole subject the better off we shall be. We earnestly request those who are interested in the subject, and those who are expected to act upon it at the next Councillors' meeting, to converse with lawyers in regard to the powers conferred by the existing charter of the Society. They can then decide how far they are ready to endorse the views of those who for the last eighty years have studied the subject, and who have thought it expedient to take no action upon the expulsion of members for any asserted belief in exclusive therapeutic views.

Having said thus much in reference to the interpretation of our existing charter, we should imperfectly fulfil our duty did we not further say that great injustice would be done to an honorable and learned Society were its members compelled to associate on terms of equality with ignorance or imposture. But against the former the requisites for admission to the Society are a guarantee, and as to the latter it is plain that dishonesty or imposture as such would be good cause of expulsion. The practical safety of the Society grows out of the infinitesimal number of homœopaths and other exclusive practitioners within its ranks and their infinitesimal influence and weight in its deliberations. This we believe will always ensure the safety of a medical society constituted like ours. But to those who think differently, one of two courses is open—first, to contrive some way under the existing charter of the present Massachusetts Medical Society by which a sound, straightforward and intelligent physician, who is guided by the best medical light of the age, can exclude from the ranks of the Society another member of more oblique vision and medical practice. Second, to devise a new charter, the language of which will exclude from the ranks of a new society for the next hundred years all forms of medical practice which shall be unequivocally objected to by a large majority of its members.

We are induced to discuss this matter from our deep interest in the welfare of an institution which has done so much for the dignity and honor of our profession, and whose efficiency we are unwilling to see endangered by unwise or hasty action. The present question is to be decided by legal considerations, and we trust that our readers may give their attention to this portion of the subject.

#### DELIVERY OF FŒTUS BY THE RECTUM.

Dr. PECK, of Iowa, in his report of a case of extra-uterine foetation and connection of the sac with the rectum, which we copied from the *Medical and Surgical Reporter* into the *JOURNAL* of July 14, has committed an error in calling it unique. By referring to the Catalogue of the Warren Anatomical Museum, we find that there is in that collection the foetus, sac and neighboring parts from a woman 40 years of age, who had died insane, and in whose case nothing was known of an extra-uterine foetation. The sac which contained the foetus was in the lower part of the abdomen, with strong adhesions to the neighboring parts. The foetus lay free in the cavity, and had probably reached the full term. A few loose bones and some fecal matter were also found in the sac, which communicated with the rectum by two small openings. One or two small bones were found in the intestines. There are also in the Museum the bones of a foetus which were discharged from the rectum of a patient of Dr. D. H. Storer's, in which case the patient recovered. In the collection of the Boston Society for Medical Improvement there is a foetus which was removed by the late Dr. Miller through the abdominal parietes. On the following day, the faeces were seen about the wound, so that an opening must have existed between the sac and the intestinal canal. It is also interesting to mention a similar collection of bones in the latter Museum, which were removed from the urinary bladder by the operation of lithotomy.

THE BRITISH MEDICAL JOURNAL ON DEATHS FROM CHLOROFORM. *Mr. Editor*.—The *British Medical Journal* for July 2, 1870, has a summary of the deaths from chloroform



"in the leading medical journals during the last year and the early part of the present year." His necrology amounts only to ten. We beg to call attention to this point. Your able cotemporary must mean to include in his notice only those medical journals which are printed in Great Britain proper; for on page 301 of Volume IV. of this JOURNAL there was quoted from the *Australian Medical Journal* a circumstantial account of a death from chloroform in the Owen's District Hospital, in Australia, during 1869. This is not one of the *British Medical Journal's* list of ten. In this JOURNAL, also, between July 1st, 1869, and January, 1870, are reported six instances of fatal inhalation of chloroform not alluded to by your cotemporary. These latter cases occurred in this country. The *Medical News and Library* "recorded" in 1869 twenty-five cases of chloroform death. From the form of the statement we infer that most of these twenty-five instances took place within the year in question. r.

**PRIZE COMMITTEE ON VENTILATION OF SICK-ROOMS.**—At a meeting held June 16—present, Drs. Lyman, Clark and Wyman—various plans for ventilation were brought forward and considered. Some of them were very ingenious and effectual for the objects proposed by their inventors; but too complicated and expensive for general use. None of them, in the opinion of the Committee, met the terms proposed, viz.: "An effective and ready method of ventilating sick-rooms that can be put in operation at the needed moment, with the least difficulty and expense, in houses of ordinary construction."

It was therefore voted: That the time for the reception of the plans of competitors for the prize of fifty dollars be extended to October 1st, 1870.

Cambridge, July, 1870.

M. WYMAN.  
Chairman.

**SIMPSON MEMORIAL.**—A deputation from the Edinburgh committee formed for erecting a suitable memorial to Sir James Y. Simpson has been in London for some days organizing a corresponding committee. As the result of their labors, a meeting of a private character was held on Thursday afternoon at Stafford House, by permission of the Duke of Sutherland. The circular calling the meeting was signed by the Duke of Sutherland, Earl of Dalhousie and Lord Elcho. His Grace the Duke of Sutherland presided. The following resolutions were proposed:—

I. That this meeting cordially approves of the proposal to endeavor in some suitable way to perpetuate the memory of Sir James Simpson—one who has done so much for scientific medicine, and to assuage the sufferings of the human race.

II. That without undervaluing the proposal that has been made to erect a statue in the metropolis of his native country, this meeting is of opinion that no commemoration of a man so eminently practical would be complete which did not embrace the establishment of an hospital where the diseases peculiar to females could be treated, which every friend of the late Sir James Y. Simpson knows was an object ever near his heart.

III. That this meeting is of opinion that a committee should be formed in London to co-operate with the other committees, and to secure the establishment of a suitable and lasting memorial of the fame and character of the deceased.

The Duke of Sutherland, Hon. Mr. Kinaird, M.P., Lord Elcho, and Drs. William Playfair and Black were appointed on the committee.—*London Medical Times and Gazette*, June 25.

**HISTORY OF THE OPERATION OF THE CÆSAREAN SECTION.**—According to Prof. T. Gallard Thomas, M.D. New York (*Am. Jour. of Obstetrics*), this operation was practised among the Jews; it was a recognized operation during the Greek civilization, and during the Roman it received the name under which it is known to us. The first case in which it was resorted to in later times for the removal of a child from the body of a living woman, which can be regarded as really authentic, dates back only to about the period of the discovery of this country, 1491.—*N. Y. Medical Record*.

**INSANITY IN PENNSYLVANIA.**—Estimating the population of this State at 3,500,000, the number of the insane will be 5,833—one in six hundred. One third of these may not need hospital treatment. Deducting these, we have 3,889 for whom some hospital provision is required. The number of patients in the proper hospitals and asylums is about 1,700, so that there still remain 2,189 who are without the only suitable care and treatment.—*American Journ. of Insanity*.

**A PRECOCIOUS MOTHER.**—The Registrar-General of England reports the case of a daughter of an Essex laborer who gave birth to a child before she was 11 years of age.

## Medical Miscellany.

**THE ANTISEPTIC SYSTEM IN SURGERY.**—At a recent meeting of the Medical Society of Berlin, the leading surgeons of that city recorded their experience of the carbolic acid treatment of injuries and wounds. Prof. Bardeleben stated that, in two hundred and forty-two cases then in hospital, the success of this treatment was fully confirmed. Fifty of these were serious cases, and three of them compound fractures, which, but for Lister's method, must have been amputated. He had found very good results and less irritation from the use of sulpho-carbolate of zinc, as employed by Mr. Wood, of King's College Hospital. Prof. Langenbeck stated that, although at first he had the greatest distrust of Lister's method, yet two years' experience of it had now so convinced him of its utility, that hardly any operation was now performed in his clinic without the use of carbolic acid. He also had recently two compound fractures of the leg, which, according to still prevailing doctrines, should have been amputated, but had both run a favorable course under the carbolic acid treatment. Prof. Lister, commenting on this discussion in the current number of the *Edinburgh Medical Journal*, observes that the "poisonous action" with which M. Bardeleben has met in one of ten cases, has not occurred at all in his own practice since lac-plaster was substituted for the paste. The local irritation complained of he ascribes to the omission of the use of a "protective" to guard the wound from the direct action of the acid.—*Brit. Med. Jour.*

WE presume we have now heard the last of that execrable impostor, the *soi-disant* Dr. Newton, miracle-worker from America. Like the Zouave Jacob, and others of similar notoriety, "every dog has his day"—so with this latest importation of impudence and falsehood, the populace will suffer him no longer, and at his last performance, at a Baptist chapel in Paddington, he was most unceremoniously mobbed, and it was only by his acrobatic accomplishments that he was enabled to escape the fury of the mob by scaling a garden wall—for him a miracle—as it saved him the chastisement, if not the lynching, he so richly deserved. The Baptist minister, also, who pretended to be a believer, and who had lent his chapel to the fellow, did not altogether escape with that delicate treatment he might have desired. Give such men enough rope and they will soon hang themselves—particularly if the public are allowed to be the judges.—*Dublin Medical Press & Circular.*

**HOSPITAL FOR SCROFULOUS CHILDREN.**—The Department of Public Health of France has founded near Calais a sea-side hospital for the treatment of scrofulous children from Paris. In consequence of the success of the experiments undertaken in 1861, with an hospital of 100 beds, the department has provided accommodation somewhat in proportion to the wants of the Parisian population, and has caused an hospital of 500 beds to be erected. The Empress inaugurated it in July last. Desiring, however, to secure the benefit of sea-side treatment, not only

for the destitute, but for the children of persons whose means would not allow them to incur the expense of a residence at the sea, the management has opened the small hospital to children whose expenses of maintenance (1*fr.* 80*c.* per day) are paid.—*Ibid.*

A LETTER received by a well-known London physician, dated from Munich on the 26th ult., gives a favorable account of the great chemist's recovery. Prof. Liebig's health continues to improve daily.—*Med. Times & Gaz.*, July 2.

DR. AUGUSTUS C. HAMLIN, of Bangor, Me., has been notified by the Surgeon-General, U.S.A., that in case of actual war in Europe he will be appointed special commissioner to report upon the hospital and medical systems of the armies of France and Prussia.

TO CORRESPONDENTS.—Communication accepted.—Simple Dressing by continued Moisture.

**PAMPHLETS RECEIVED.**—On Cholera and Choleraic Diarrhoea: their Nature, Cause and Treatment. Two Lectures, delivered at the Church Missionary College, Islington, by George Johnson, M.D., London. Pp. 45. —Hypertrophy of the Muscular Walls of the Mucous Arteries in Chronic Bright's Disease. By George Johnson, M.D., London. Pp. 8.—Forty-fifth and Forty-sixth Annual Reports of the Officers of the Retreat for the Insane, at Hartford, Conn. Pp. 56.

**Deaths in seventeen Cities and Towns of Massachusetts for the week ending July 23, 1870.**

Cities and towns.	Number of deaths in each place.	Prevalent Diseases.		
		Cholera Infantum.	Consumption.	Dysentery & Diarrhoea.
Boston . . . . .	181	58	14	12
Charlestown . . . .	9	1	2	0
Worcester . . . . .	22	10	3	1
Lowell . . . . .	34	11	2	3
Milford . . . . .	10	1	0	0
Chelsea . . . . .	4	1	2	0
Cambridge . . . . .	28	11	5	1
Salem . . . . .	14	6	0	2
Lawrence . . . . .	18	4	0	0
Springfield . . . .	6	4	0	0
Lynn . . . . .	9	7	0	0
Pittsfield . . . . .	4	0	1	2
Fitchburg . . . . .	8	5	0	1
Taunton . . . . .	5	1	2	0
Newburyport . . . .	5	0	1	0
Fall River . . . . .	11	6	1	2
Haverhill . . . . .	6	1	2	0
	377	127	36	25

Worcester reports one death from smallpox. From all the above places five deaths are reported from sunstroke.  
GEORGE DEBBY, M.D.,  
Secretary of State Board of Health.

**DEATHS IN BOSTON for the week ending July 23d, 1871.** Males 88—Females 93.—Accident, 6—anaemia, 2—apoplexy, 1—asthma, 1—disease of the bowels, 1—inflammation of the bowels, 1—congestion of the brain, 1—disease of the brain, 8—inflammation of the brain, 1—bronchitis, 4—cancer, 1—cholera Infantum, 58—cholera morbus, 4—consumption, 15—convulsions, 5—debility, 2—diarrhoea, 8—dropsy, 2—dropsy of the brain, 5—dysentery, 4—erysipelas, 1—scarlet fever, 1—typhoid fever, 3—gastritis, 1—haemorrhage, 1—disease of the heart, 5—homicide, 2—intemperance, 2—disease of the kidneys, 2—inflammation of the lungs, 2—marasmus, 6—measles, 2—old age, 2—paralysis, 3—peritonitis, 1—pleurisy, 3—premature birth, 1—sunstroke, 1—teething, 4—unknown, 6.

Under 5 years of age, 113—between 5 and 20 years, 13—between 20 and 40 years, 21—between 40 and 60 years, 17—above 60 years, 18. Born in the United States, 138—Ireland, 26—other places, 17.